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DEPARTMENT OF THE ARMY
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DEPARTMENT OF THE AIR FORCE
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MEDICAL SERVICE

Joint Armed Forces

NOMENCLATURE AND METHOD OF RECORDING PSYCHIATRIC CONDITIONS

UNITED STATES ARMY • UNITED STATES NAVY
UNITED STATES AIR FORCE

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Section I.—Introduction

1. Purpose and Plan of Classification

The primary purpose of this publication is to provide a nomenclature of psychiatric conditions consistent with the concepts of modern psychiatry. The scheme employs the term "disorder" generically to designate a group of related psychiatric conditions. In general, each such group is broken down into specific psychiatric conditions labeled "reactions." However, by way of exception, the generic group "Character and Behavior Disorders" is broken down in part into "Pathological Personality Types," and the "Disorders of Intelligence" are broken down into "Mental Deficiency" and "Specific Learning Defects."

The psychoneuroses are classified on the basis of the dynamics of their psychopathology. Of necessity, a few terms have remained descriptive (symptomatic). "Catch-all" terms such as "simple adult maladjustment" and "constitutional psychopathic state" have been eliminated from this classification.

Each term used in the classification is defined in detail under "definitions" (sec. II). The manner of recording of psychiatric conditions on individual medical records and on clinical records is presented in sections III and IV, respectively. Whenever it seemed necessary, the recording procedures have been illustrated by examples.

2. Classification of Psychiatric Conditions [1]

a. Psychotic disorders:

(1) Schizophrenic reactions:
- (*a*) Schizophrenic reaction, simple type (3000).
- (*b*) Schizophrenic reaction, hebephrenic type (3001).
- (*c*) Schizophrenic reaction, catatonic type (3002).
- (*d*) Schizophrenic reaction, paranoid type (3003).
- (*e*) Schizophrenic reaction, latent (3005).
- (*f*) Schizophrenic reaction, NEC (3007).

(2) Affective reactions:
- (*a*) Manic-depressive reaction (3010).
- (*b*) Psychotic depressive reaction (3111).
- (*c*) Involutional Melancholia (3112).

(3) Paranoid reactions:
- (*a*) Paranoia (3015).
- (*b*) Paranoid state (3016).

b. Psychiatric disorders with demonstrable physical etiology or associated structural changes in the brain:

(1) Psychotic disorders with demonstrable physical etiology or associated structural changes in brain (3040).

(2) Nonpsychotic mental disorders with demonstrable physical etiology or associated structural change in brain (3041).

[1] Numbers in parenthesis refer to Joint Armed Forces statistical classification and basic diagnostic nomenclature.

c. Psychoneurotic disorders:

(1) Anxiety reaction (3100).
(2) Dissociative reaction (3110).
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(4) Phobic reaction (3120).
(5) Obsessive-compulsive reaction (3130).
(6) Neurotic depressive reaction (3140).
(7) Somatization reactions:
    (*a*) Psychogenic cardiovascular reaction (3150).
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    (*d*) Psychogenic genito-urinary reaction (3171).
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    (*h*) Psychogenic reactions affecting other systems (3179).
(8) Hypochondriacal reaction (3180).

d. Character and behavior patterns:

(1) Pathological personality types:
    (*a*) Schizoid personality (3200).
    (*b*) Paranoid personality (3201).
    (*c*) Cyclothymic personality (3202).
    (*d*) Inadequate personality (3203).
    (*e*) Antisocial personality (3204).
    (*f*) Asocial (Amoral) personality (3205).
    (*g*) Sexual deviate (3206).
(2) Immaturity reactions:
    (*a*) Emotional instability reactions (3210).
    (*b*) Passive dependency reaction (3211).
    (*c*) Passive-aggressive reaction (3212).
    (*d*) Aggressive reaction (3213).
    (*e*) Immaturity with symptomatic habit reaction (3215).
(3) Alcoholism (except simple drunkenness or acute poisoning due to alcohol) (3221).
(4) Addiction (3230).
(5) Primary childhood behavior reaction (3240).

e. Disorders of intelligence:

(1) Mental deficiency, primary (3250).
(2) Mental deficiency, secondary (3260).
(3) Specific learning defect (3270).

f. Transient personality disorders due to acute or special stress:

(1) Combat exhaustion (3273).
(2) Acute situational maladjustment (3274).

Section II.—Definitions

3. Psychotic Disorders Without Known Organic Etiology

These disorders are characterized by a varying degree of personality disintegration and failure to test and evaluate correctly external reality in various spheres. In addition, individuals with such disorders fail in their ability to relate themselves effectively or happily to other people or to their own work. No organic basis is known.

a. Schizophrenic reactions.—This term represents a group of psychotic disorders characterized by fundamental disturbances in reality relationships and concept formations with consequent affective behavioral and intellectual disturbances in varying degrees and mixtures. The disorders are marked by strong tendency to retreat from reality, by emotional disharmony unpredictable disturbances in stream of thought, and in some patients by a tendency to deterioration.

It is not essential to forcibly classify such patients into a Kraepelinian type. The predominant symtomatology will be the determining factor in classifying such patients.

(1) *Schizophrenic reaction, simple type.*—This type of reaction is characterized chiefly by reduction in external attachments and interests and by impoverishment of human relationships. It often involves adjustment on a lower psychobiologic level of functioning, usually accompanied by apathy and indifference, but rarely by conspicuous delusions or hallucinations. In contrast to the long history of the schizoid personality, showing slight or no change in symptomatology, the simple type of schizophrenic reaction characteristically manifests a marked increase in the severity of symptoms over long periods.

(2) *Schizophrenic reaction, hebephrenic type.*—Such reactions are characterized by shallow inappropriate affect, unpredictable giggling, silly behavior and mannerisms, delusions often of a somatic nature, and hallucinations.

(3) *Schizophrenic reaction, catatonic type.*—This reaction is characterized by conspicuous motor behavior, exhibiting either marked generalized inhibition (stupor, mutism, negativism, and waxy flexibility), or excessive motor activity and excitement. The individual may regress to a state of vegetation.

(4) *Schizophrenic reaction, paranoid type.*—This type of reaction is characterized by schizophrenic unrealistic thinking and unpredictable behavior, with mental content composed chiefly of delusions of persecution, occasionally of grandeur, hallucinations, a fairly constant attitude of hostility and aggression, and ideas of reference. Excessive religiosity may be present and, rarely, there may be no delusions of persecution. Instead there may be an expansive and productive delusional system of omnipotence, genius, or special ability. The systematized paranoid hypochondriacal states are included in this group.

(5) *Schizophrenic reaction, latent.*—Certain individuals are found on examination to present definite schizophrenic ideation and behavior (e. g., mannerisms, unpredictable acts), beyond that of the schizoid personality, but not of an advanced stage as in acute or chronic schizophrenic reactions. These individuals may be incipient schizophrenics, and they may maintain their borderline adjustment over long periods. Among their friends, these individuals are regarded merely as queer or eccentric; under close examination, however, they show evidence of psychotic symptoms. They represent essentially borderline psychoses.

Important diagnostic evidence of such reactions consists of disordered conceptual (categorical) thinking as manifested in special tests, such as the Rorschach test, the Vigotsky (Hanfman-Kasanin) category tests, the sorting

tests, (Goldstein-Sheerer, Rapaport, and Halstead) proverbs and problems (J. Benjamin, N. Cameron), and the Murray Thematic Apperception Test. Hospitalization of such cases is rarely necessary.

(6) *Schizophrenic reactions, not elsewhere classified (n. e. c.).*—There are two large groups (acute and chronic) of schizophrenic reactions which cannot be appropriately classified under the preceding types. In all cases where this diagnosis is made, the important descriptive features will be specified; e. g., Schizophrenic Reaction. unclassified, acute, with confusion, ideas of reference, elation, and excitement.

(a) *Acute.*—The acute group of this reaction includes cases exhibiting a wide variety of schizophrenic symptomatology, such as confusion of thinking and turmoil of emotion, manifested by perplexity, ideas of reference, fear and dream states, and dissociative phenomena. These symptoms appear precipitously, often without apparent precipitating stress, but exhibiting historical evidence of prodromal symptoms. Very often it is accompanied by a pronounced affective coloring of either excitement or depression. The symptoms often clear in a matter of weeks, although there is a tendency for them to recur.

(b) *Chronic.*—The chronic schizophrenias exhibit a mixed symptomatology, and when the reaction cannot be classed in any of the preceding main types, it should be placed in this group.

b. Affective reactions.—

(1) *Manic-depressive reaction.*—This term is synonymous with the term manic-depressive psychosis. This reaction will be further qualified by one of the following appropriate terms: manic, depressive; stuperous; circular; agitated; with schizophrenic coloring; and mixed.

(2) *Psychotic depressive reaction.*—This reaction differs from the manic-depressive reaction principally in absence of history of repeated depressions and frequently in presence of obvious environmental precipitating factors. The patient manifests evidence of gross misinterpretation of external reality (e. g., matters of guilt and unworthiness).

This reaction differs from neurotic depressive reaction chiefly in degree.

(3) *Involution melancholia.*—This reaction is characterized most commonly by depression, with or without agitation, without previous history of either manic or depressive illnesses. It occurs in the individual's middle life and in his later years. It tends to have a prolonged course and may be manifested by worry, guilt, anxiety, agitation, paranoid and other delusional ideas, and somatic concerns. Some cases are characterized chiefly by depression and others chiefly by paranoid ideas. Often these reactions are accompanied by gastrointestinal or other somatic concerns to a delusional degree.

c. Paranoid reactions.—

(1) *Paranoia.*—This type of psychotic disorder is extremely rare. It is characterized by an intricate, complex, and slowly developing paranoid system with the individual usually regarding himself as particularly singled out. The patient often endows himself with superior or unique ability, and even considers himself appointed for a Messianic mission. The paranoid system is particularly isolated from much of the normal stream of consciousness, without hallucinations and with relative intactness and preservation of the remainder of the personality.

(2) *Paranoid state.*—This type of paranoid reaction is characterized by paranoid delusions. It lacks the logical nature of systematization seen in paranoia; yet it does not manifest the bizarre fragmentation and deterioration of the schizophrenic. It occurs most frequently in individuals between 35 and 55 years of age, and it is ordinarily of a relatively short duration, though it may be persistent and chronic.

4. Psychiatric Disorders With Demonstrable Physical Etiology or Associated Structural Changes in the Brain

Mental disorders due to impaired brain function, secondary to infection, or intoxication, trauma, disturbances of circulation, convulsive disorders, disturbances of metabolism, growth, nutrition or endocrine dysfunction, cerebral neoplasm, degenerative diseases, and unknown or hereditary causes, are to be regarded as symptoms of the underlying physical (nonpsychiatric) condition with which they are

associated. . These psychiatric disorders may be either psychotic or nonpsychotic.

a. *Psychotic reaction.*—Whenever the psychiatric condition of such cases is psychotic, it will be reported as a "psychotic reaction" of a particular type, amplified by one of the following descriptive terms: Schizoid, paranoid, depressed, manic, confused, anxious, agitated, panic, delirious, and apathetic. This category includes psychoses associated with infections (general paresis, meningovascular syphilis, epidemic encephalitis, and so forth) : psychoses associated with exogenous poisonings; and other associated psychoses such as those accompanying pellagra, cerebral embolism, Huntington's chorea, etc.

b. *Nonpsychotic mental reactions.*—Whenever the psychiatric condition of such cases is nonpsychotic and resembles in part one of the "Character and behavior disorders" or one of the "Psychoneurotic disorders" such resemblance will be recorded as an amplification of the diagnosis.

Nonpsychotic mental conditions which do not resemble any of the last-mentioned clinical titles will be reported as nonpsychotic reactions, amplified by a description of their manifestations, such as irritability, memory defect, mild confusion, euphoria, etc. (See par. 11*b* (2) for examples of recording.) Mental deficiency, secondary will not be recorded in this category.

5. Psychoneurotic Disorders

This generic term refers to psychiatric disorders resulting from the exclusion from consciousness (i. e., repression) of powerful emotional charges, usually attached to certain infantile and childhood developmental experiences. Hereditary, constitutional organic situational, and cultural factors are involved, but the extent to which they are contributory to the particular disorder is difficult to determine. However, these factors should be carefully considered in evaluating "external precipitating stress" and "premorbid personality and predisposition" (pars. 13 and 14). These repressed emotional charges, which may not be apparent without an extensive and deep investigation of the personality, may or may not be adequately controlled in the absence of external stress. Longitudinal (lifelong) studies of individuals with such disorders usually present evidence of periodic or constant maladjustment of varying degree. Special stress may make the symptomatic expressions of such disorders acute.

The chief characteristics of these disorders is "anxiety," which may be either "free floating" and unbound ("anxiety reaction"), and directly felt and expressed, or it may be unconsciously and automatically controlled by the utilization of various psychological defense mechanisms (repression, conversion, displacement, etc.). In contrast to psychotics, patients with psychoneurotic disorders do not exhibit gross distortion or falsification of external reality (delusions, hallucinations, illusions) and they do not present gross disorganization of the personality.

Anxiety in psychoneurotic disorders is a danger signal felt and perceived by the conscious portion of the personality (ego). Its origin may be a threat from within the personality—expressed by supercharged repressed emotions, including particularly such aggressive impulses as hostility and resentment—with or without stimulation from external situations, as loss of love or prestige, or threat of injury.

The various ways in which the patient may attempt to handle this anxiety will result in the various types of reactions listed below.

In recording such reactions, the terms "traumatic neurosis" or "traumatic" reaction will not be used. Instead the particular psychiatric reaction will be specified. Depending on the nature of the coexisting psychiatric and physical conditions, these will be recorded ether as separate diagnoses or as one diagnosis (par. 11). Likewise, the term "mixed reaction" will not be used; instead, the predominant type of reaction will be recorded, qualified by reference to the other types of reactions as part of the symptomalogy.

a. Anxiety reaction.—In this type of reaction the anxiety is diffuse and not restricted to definite situations or objects as in the case of the phobia. Furthermore, it is neither "bound" nor controlled by any psychological defense mechanism, as in the other psychoneurotic disorders.

This reaction should be distinguished from normal apprehensiveness or fear. The term is synonymous with the former term "anxiety state."

b. Dissociative reaction.—This psychoneurotic reaction represents a type of personality disorganization which proves to be in the majority of instances a neurotic disturbance. The diffuse dissociation seen in some cases of acute combat exhaustion may occasionally appear psychotic, but nearly always the reaction becomes neurotic.

In acute cases of such reaction, the personality (ego) disorganization appears to permit the anxiety to overwhelm and momentarily govern the total individual, resulting in aimless running or "freezing." In other cases, the repressed impulse giving rise to the anxiety, may be either discharged or deflected into various symptomatic expressions such as fugue, amnesia, etc. Often this may occur with little or no participation on the part of the conscious personality.

These reactions should be differentiated from schizoid personality, schizophrenic reactions, and from analogous symptoms in some other types of neurotic reactions. Formerly, this reaction has been often classified as a type of "conversion hysteria."

The diagnosis should specify the symptomatic manifestations of the reaction, such as depersonalization, dissociated personality, stupor, fugue, amnesia, dream state, somnambulism, etc.

c. Conversion reaction.—This term is synonymous with "conversion hysteria." Instead of being experienced consciously (either diffusely or displaced, as in phobias), the impulse causing the anxiety in conversion reaction is "converted" into functional symptoms in organs or parts of the body, mainly under voluntary control. Often, such reactions meet the immediate needs of the patient and are, therefore, associated with obvious "secondary gain." They are to be differentiated from somatization reactions (par. 5 *g*).

In recording such reactions, the symptomatic manifestations will be specified, as anesthesia (anosmia, blindness, deafness), paralysis (paresis, aphonia, monoplegia or hemiplegia), dyskinesis (tic, tremor, postures, catalepsy). However, if the manifestations do not fit the conversion patterns of immediate need and if they do not represent the result of chronic emotional tension states, the reactions will be properly classified under somatization reactions (par. 5 *g*).

d. Phobic reaction.—By an automatic mental mechanism, the anxiety of these patients becomes detached from some specific idea or sit-

uation in the daily life behavior and is displaced to some symbolic idea or situation in the form of a specific neurotic fear. In civilian life, the commonly observed forms of phobic reactions include fear of syphilis, dirt, closed places, high places, open places, some animals, and so forth. In military life, other specific weapons, combat noise, planes, and so forth. The patient attempts to control his anxiety by avoiding the phobic object or situation.

In this group of reactions are included the sensitized residual states of combat exhaustion reaction observed after the other acute manifestations have subsided. In recording this diagnosis, the manifestations will be indicated. This term is synonymous with the former term "phobia." This reaction also includes some of the cases formerly known as "anxiety hysteria."

e. Obsessive-compulsive reaction.—In this reaction the anxiety may be observable in connection with obsessional fear of uncontrollable impulses. On the other hand, the anxiety may be under apparent control, through a mental mechanism (isolation), by which the emotional charge becomes automatically separated from the main stream of consciousness and often manifests itself in a displaced form through useless, excessive, or repetitive activity. In the latter instances, the patient is utilizing the mental mechanisms of "undoing"—a symbolic act which temporarily protects the patient against a threat—and "displacement." The patient himself may regard his ideas and behavior as unreasonable and even silly, but nevertheless is compelled to carry out his rituals.

The diagnosis should specify the symptomatic expressions of such reactions, as touching, counting, ceremonials, handwashing, recurring thoughts, accompanied often by compulsion to repetitive action. This category includes many cases formerly classified as "psychasthenia."

f. Neurotic depressive reaction.—The anxiety in this reaction is allayed and hence partially relieved by self-depreciation through the mental mechanism of introjection. The reaction is often associated with the feeling of guilt for past failures or deeds. The reaction is a nonpsychotic response precipitated by a current situation, frequently by some loss sustained by the patient, although dynamically the depression is usually related to repressed (unconscious) aggression. The degree of the reaction in such cases is dependent upon the intensity of the patient's ambivalent feeling toward his loss (love, possessions, etc.), as well as upon the realistic circumstances of the loss.

The term is synonymous with "reactive depression". This reaction must be differentiated from the corresponding psychotic reaction (par. 3*b* (2)).

g. Somatization reactions.—The term is used in preference to "psychosomatic reactions," since the latter term refers to a point of view on the discipline of medicine as a whole rather than to certain specified conditions.

These reactions represent the visceral response to the anxiety which may be thereby largely prevented from being conscious. The symptom is due to a chronic and exaggerated state of the normal psysiology of the emotion, with the feeling or subjective part repressed. Long continued visceral dysfunction may eventuate in structural changes.

This group includes the so-called organ neuroses. It also includes some of the cases formerly classified under a wide variety of diag-

nostic terms, such as "conversion hysteria," "anxiety state," "cardiac neurosis," "gastric neurosis," and so forth.

Each diagnosis of this type of reaction should be amplified with the specific symptomatic expressions, e. g., anorexia, loss of weight, dysmenorrhea, hypertension, and so forth.

(1) *Psychogenic cardiovascular reaction.*—This subcategory includes most cases of such established types of cardiovascular disorders as paroxysmal tachycardia, pseudoangina pectoris, and some types of hypertension.

Neurocirculatory asthenia has been classically defined as an "anxiety reaction"; similar clinical pictures, without subjective anxiety, will be classified as psychogenic cardiovascular reaction. When this diagnosis is used the outstanding symptomatic expressions will be specified.

(2) *Psychogenic gastrointestinal reaction.*—This subcategory may include some instances of such specified types of gastrointestinal disorders as peptic-ulcer-like reaction, chronic gastritis, mucous colitis, constipation, hyperacidity, pylorospasm, "heart-burn," "irritable colon," and so forth. In making this diagnosis, the outstanding symptoms will be specified.

(3) *Psychogenic respiratory reaction.*—This subcategory includes cases of bronchial spasm, hyperventilation, and sighing respirations which are of emotional origin. It also includes induced tetany.

(4) *Psychogenic genitourinary reaction.*—This subcategory includes some types of menstrual disturbances, impotence, frigidity, dysuria, and so forth.

(5) *Psychogenic skin reaction.*—This subcategory includes the so-called neurodermatoses, dermographia, and other related reactions, when involving major emotional factors. In using this diagnosis, specify manifestations.

(6) *Psychogenic musculoskeletal reaction.* This subcategory includes musculoskeletal complaints which are emotional in their origin. It includes so-called "psychogenic rheumatism," backache, and so forth.

(7) *Psychogenic asthenic reaction.*—General fatigue in the predominating complaint of such reaction. It may be associated with visceral complaints. Present weakness and fatigue may indicate a physiological neuro-endocrine residue of previous anxiety and not necessarily an active psychological conflict. The term includes many cases formerly termed "neurasthenia." In some instances, an asthenic reaction may represent a conversion reaction; if so, it should be so classified, with asthenia as a manifestation. In other instances it may be a manifestation of an anxiety reaction and should be recorded as such.

(8) *Psychogenic rections affecting other systems.*—It is not intended that the reactions listed above be interpreted as necessarily including all possible reactions of this sort. If analogous additional reactions are recorded as diagnoses, they should be clearly identified as psychogenic. The diagnosis should specify the system involved and the particular symptomatic expressions.

h. Hypochondriacal reaction.—This particular psychoneurotic reaction is characterized by obsessive concern of the individual about the state of his health or the condition of his organs. It is often accompanied by a multiplicity of complaints about different organs or body systems. Some of such reactions may become excessively and persistently obsessional and develop associated compulsions. Such cases may be classified more accurately as "obsessive-compulsive reaction" (par. 5*e*).

In general, this type of reaction should be carefully differentiated from depressive reactions, obsessive-compulsive reactions, symptoms of early psychotic reactions, and various specific somatization reactions. This term is synonymous with "hypochondriasis."

6. Character and Behavior Disorders

Such disorders are characterized by developmental defects or pathological trends in the personality structure, with minimal subjective anxiety, and little or no sense of distress. In most instances, the disorder is manifested by a lifelong pattern of action or behavior ("acting

out"), rather than by mental or emotional symptoms. Occasionally, organic diseases of the brain (chronic epidemic encephalitis, head injury, epilepsy, and so forth) will produce clinical pictures resembling a character or behavior disorder.

a. Pathological personality types.—The maladjustment of many individuals is evidenced in lifelong abnormal behavior patterns. Such individuals are generally described as pathologic personality types. These may be likened to abortive stages in the evolution of psychoneuroses or psychoses. Such behavior patterns do not usually progress to the stage of a psychosis, nor do they justify a diagnosis of any type of neurosis, although they may show some characteristics of both. They represent borderline adjustment states. The following pathological personality types will be differentiated:

(1) *Schizoid personality.*—Such individuals react with unsociability, seclusiveness, serious mindedness, nomadism, and often with eccentricity.

(2) *Paranoid personality.*—Such individuals are characterized by many traits of the schizoid personality, coupled with a conspicuous tendency to utilize a projection mechanism, expressed by suspiciousness, envy, extreme jealousy, and stubbornness.

(3) *Cyclothymic personality.*—Such individuals are characterized by frequently alternating moods of elation and sadness, stimulated apparently by internal factors rather than by external events. The individual may occasionally be either persistently euphoric or depressed, without falsification or distortion of reality. The diagnosis in such cases should specify, if possible, whether hypomanic, depressed, or alternating.

(4) *Inadequate personality.*—Such individuals are characterized by inadequate response to intellectual, emotional, social, and physical demands. They are neither physically nor mentally grossly deficient on examination, but they do show inadaptability, ineptness, poor judgment, and social incompatibility.

(5) *Antisocial personality.*—The term refers to chronically antisocial individuals who, despite a normal moral background, are always in trouble, profiting neither from experience nor punishment, and maintaining no real loyalties to any person, group, or code. Ordinarily, an individual of this type is not a calculating criminal, but one who is often on the verge of criminal conduct and may eventually become involved in such conduct.

This term includes most cases formerly classed as "constitutional psychopathic state" and "psychopathic personality." As defined here, the term is more limited, as well as more specific in its application.

(6) *Asocial (Amoral) personality.*—This term applies to individuals who manifest disregard for social codes and often come in conflict with them as the "normal" result of having lived all their lives in an abnormal moral environment. They often become gangsters, vagabonds, racketeers, and prostitutes. This term includes most cases formerly designated as "psychopathic personality, with asocial and amoral trends."

(7) *Sexual deviate.*—This diagnosis is reserved for deviant sexuality which is not symptomatic of more extensive syndromes such as schizophrenic and obsessional reactions. The term includes most of the cases formerly class as "psychopathic personality with pathologic sexuality." The diagnosis will state whether the condition is overt or latent, and specify the type of the pathologic behavior, such as homosexuality, transvestism, pedophilia, fetishism, and sexual sadism (including rape, sexual assault, mutilation).

b. Immaturity reactions.—This category applies to physically adult individuals, who are unable to maintain their emotional equilibrium and independence under minor or major stress because of deficiencies in emotional development. Some individuals are classed in this group because their behavior disturbance is based on fixation of certain character patterns; others, because their behavior is a regressive reaction due to severe stress.

The classification will be applied only to cases of character and behavior disorders in which the neurotic features (such as anxiety, conversion, phobia, and so forth) are relatively insignificant and the basic

personality maldevelopment, not anxiety, is the crucial distinguishing factor. Evidence of physical immaturity may or may not be present.

The diagnosis should report the specific immaturity reaction as defined below.

(1) *Emotional instability reaction.*—In such cases the individual reacts with excitability and ineffectiveness when confronted with minor stress. His judgment may be undependable under stress, and his relationship to other people is continuously fraught with fluctuating emotional attitudes, because of strong and poorly controlled hostility, guilt, and anxiety which require quick mobilization of defense for the protection of the ego.

This term is synonymous with the former term "psychopathic personality, with emotional instability."

(2) *Passive-dependency reaction.*—This reaction is characterized by helplessness, indecisiveness, and a tendency to cling to others. The clinical picture in such cases is often associated with an anxiety reaction which is typically psychoneurotic. There is a predominant child-parent relationship in such reactions.

(3) *Passive-aggressive reaction.*—The aggressiveness is expressed in such reactions by passive measure, such as pouting, stubbornness, procrastination, inefficiency, and passive obstructionism.

(4) *Aggressive reaction.*—A persistent reaction to frustration with irritability, temper tantrums, and destructive behavior, is the dominant factor in such cases. A specific variety of this reaction is a morbid or pathological resentment. Below the surface, a deep dependency is usually evident in such cases. The term does not apply to cases more accurately described by the term "antisocial personality" (par. 5*a*).

(5) *Immaturity with symptomatic "habit" reaction.*—This category is useful in occasional situations where a specific symptom is the single outstanding expression of the psychopathology. This term should not be used as diagnosis, however, whenever the symptoms are associated with, or are secondary to, organic illnesses and defects or to other phychiatric disorders. Thus, for example, the diagnosis "immaturity with symptomatic habit reaction; speech disorder" would be used for certain disturbances in speech in which there are insufficient other symptoms to justify any other definite diagnosis. This type of speech disturbance often develops in childhood. It would not be used for a speech impairment that was a temporary symptom of conversion hysteria or the result of any organic disease or defect.

The diagnosis should specify the particular "habit" reaction, as, for instance, enuresis, speech disorder, stammering, stuttering, excessive masturbation, and so forth.

c. Alcoholism (except simple drunkenness or acute poisoning due to alcohol).—Included in this category will be cases of severe character disturbance in which there is well-established addiction to alcohol. Cases of symptomatic addiction to alcohol where the basic problem is a psychosis or severe phychoneurosis will not be classified in this category. Simple drunkenness and acute poisoning due to alcohol also are not included in this category. They are separately listed outside the section on neuropsychiatric diagnoses.

d. Addiction.—This term does not include excessive symptomatic utilization of drugs which is a symptom of depression or psychoneurosis. Cases properly described by this term represent much deeper character disturbance than do cases where the use of drugs represents a symptom of some more extensive phychiatric illness. Frequently these individuals engage in antisocial behavior, such as pugnaciousness, deception, stealing, sexual assault, and so forth, while under the influence of drug.

The term includes cases formerly classed as "drug addiction," and also some cases formerly classed as "constitutional phychopathic state."

The diagnosis should specify the drug to which addicted. Cases of addiction to alcohol will not be included in this category.

e. Primary childhood behavior reactions.—The symptoms of this large group of reactions are the expression of serious emotional difficulties within the child and not due to organic defects. The emotional display must be carried to an extreme degree before the child is classified as belonging in this group. The diagnosis should specify the manifestation of the reaction, such as night terrors, anxiety attacks, phobias, temper tantrums, extreme cruelty or jealousy, stealing, lying, sexual misbehavior, enuresis, running away from home, and so forth.

7. Disorders of Intelligence

a. Mental deficiency.—Mental deterioration associated with chronic psychoses and blocking of intellectual function by emotional conflicts should not be included in this category. In recording mental deficiency, distinction will be made between primary and secondary types of the disorder, defined as follows:

(1) *Mental deficiency, primary.*—The term will be applied to cases in which the mental retardation has been present since birth or infancy, without known organic brain disease. It includes clearly hereditary cases. In recording such disorder, the mental age should be indicated, along wtih the psychrometric test by which it was determined.

(2) *Mental deficiency, secondary.*—The term will be applied to cases of mental retardation which have resulted from an organic disease of the brain, whether congenital or acquired, such as cerebral agenesis, microcephaly, hydrocephalus, cretinism, encephalitis, birth injury, and so forth. In such cases, the mental deficiency will be recorded as a secondary diagnosis to the originating condition. The conditions should be recorded as mental deficiency, secondary, and the mental age of the individual should be specified, along with the psychometric test by which it was determined. Example: Mental deficiency, secondary. M. A. 8 years (Wechsler-Bellevue test used), reported as secondary to Hydrocephalus, congenital.

b. Specific learning defects.—The diagnosis should specify whether the defect is strephosymbolia or is in reading, mathematics, and so forth. If known, the type of encephalopathy will be stated.

8. Transient Personality Disorders Due to Acute or Special Stress

A normal personality may utilize, under conditions of great or unusual stress, established patterns of reaction to express overwhelming fear or flight reaction. The patterns of such reactions differ from those of neuroses or psychoses chiefly with respect to clinical history and reversibility of the reaction. In a great majority of such reactions, there is essentially a negative historical background.

This general classification should be restricted to reactions which are usually transient in character and to reactions which cannot be given a more definite diagnosis because of their fluid state or because of limitation of time permitted for their study.

a. Combat exhaustion.—Combat reaction is often transient in character. When promptly and adequately treated, the condition may clear rapidly, but it may also progress into one of the neurotic reactions. This term is to be regarded, therefore, as a temporary diagnosis and should be used only until a more definitive diagnosis is established. It will be used only in combat areas.

This diagnosis is justified only in situations in which the individual has been exposed to severe physical demands or extreme emotional stress in combat. In many instances, this diagnosis applies to previously more or less "normal" persons who have experienced intol-

erable stress. The patient may display a marked psychological disorganization akin to certain psychoses.

b. Acute situational maladjustment.—The clinical picture of this reaction is primarily one of superficial maladjustment to newly experienced environmental factors or to especially trying and difficult situations, with no evidence, however, of any serious long-standing or underlying personality defects or chronic neurotic patterns. It may be manifested by anxiety, alcoholism, asthenia, poor efficiency, low morale, unconventional behavior, and so forth. If untreated or not relieved, such reactions may progress in some instances into typical psychoneurotic or psychopathic reactions.

The term may be applied to reactions caused by cultural deficiencies and deprivations, when such show no definite neurotic type of reaction. It will also include some cases formerly classified as "simple adult maladjustment."

Section III.—Recording of Psychiatric Conditions; General Requirements

9. General

a. Lowest subclassification to be used in recording diagnoses.—The specific types of psychiatric conditions ("reactions") are sufficiently well defined to justify their use without inclusion of the terms indicating the broad disorder groups. In recording a psychiatric condition, the lowest subclassification of the disorder will be used without being prefaced by its generic term. Thus, for instance, an "emotional instability reaction" will be so recorded, without reference to the intermediate classification "immaturity reaction," or to its generic term "Character or Behavior Disorders."

b. Qualifying terms.—In addition to the diagnostic term used for specifying the particular psychiatric condition, the diagnosis will also include terms qualifying the severity and chronicity of the condition. The term "severity" refers to the seriousness of the condition. It should not be determined solely by the degree of ineffectiveness, since other factors, such as underlying defective attitude, or other psychiatric or physical conditions might have contributed to the total ineffectiveness. Severity will be described as "mild," "moderate," or "severe." Such terms as "moderately severe" or "mildly severe" are not sanctioned. The diagnosis will be further qualified as either "acute" or "chronic." Outstanding or conspicuous symptomatology may be added to the diagnosis. Example: "Anxiety reaction, mild, chronic, manifested by loss of appetite and insomnia." If the reaction was severe and acute upon admission, but improvement or recovery was effected with treatment, this fact will be stated. Example: "Situational maladjustment, severe, acute, improved."

c. Order of diagnoses.—The general principles prescribed by the existing regulations for recording diagnoses apply to the recording of psychiatric diagnoses. The immediate condition which necessitated the current admission of the patient to the hospital will be considered as the primary cause of admission and so recorded. In cases of several related conditions simultaneously necessitating hospitalization, the condition which is first in the chain of etiology will be designated as the primary cause. For unrelated conditions simultaneously necessitating hospitalization, the most serious condition will be recorded as the primary cause of admission. Within the limits of these general principles, the following specific conditions (pars. 10 and 11) will be considered with respect to cases involving psychiatric disorders.

10. Unrelated Diagnoses

Physical and mental disorders may coexist but be causally unrelated. In such instances all conditions will be listed as separate diagnoses,

with the primary diagnosis being selected in accordance with paragraph 9.

11. Related Diagnoses

a. General.—Physical and mental disorders may coexist and be causally related. The nature of the coexisting conditions determines whether the conditions will be recorded as separate diagnoses, or only as one diagnosis.

b. Related conditions requiring only one diagnosis.—

(1) In some instances, the mental reaction, though related to the physical disorder, is not sufficiently developed as a clinical psychiatric entity to require a formal psychiatric diagnosis. For example, a patient with pneumonia may be apprehensive and tense. While this mental status should be described in the patient's clinical history or in his physical examination along with any other symptoms or signs, on the individual medical record the diagnosis will state only the nonpsychiatric condition.

(2) There are other instances where physical and mental disorders coexist and where the physical disorder is a manifestation of the psychiatric condition rather than a separate condition. Whenever this is true, only the psychiatric condition should be listed as a diagnosis, and the physical condition should be shown as a manifestation. Example: Psychogenic gastrointestinal, reaction, severe, chronic, manifested by mucous colitis and gastric hyperacidity.

c. Related conditions requiring separate diagnoses.—

(1) Physical and mental disorders may coexist and be causally related, with both conditions being sufficiently marked and well defined to justify separate diagnoses. In such cases the causal relationship of the diagnoses should be indicated. The condition which caused or directly led to the other condition will precede the other condition in the order of diagnoses. This diagnostic procedure will be followed despite the fact that the psychiatric symptomatology is related to personality factors which existed prior to the immediate physical disease or trauma. For example in a case in which paranoid state is precipitated by skull fracture, two diagnoses would be reported: (1) Fracture, skull, simple, and so forth. (2) Paranoid state, and so forth.

(2) Definite pathological mental reactions may often be symptoms of organic disease of the brain. Such conditions may be regarded as only symptoms of the physical condition. However, such a mental reaction is sufficiently pronounced to justify its recording as a diagnosis, it will be reported as an additional diagnosis. The diagnosis will state whether the reaction is nonpsychotic or psychotic. The diagnosis if psychotic will be amplified by one of the following descriptive terms as types: schizoid, paranoid, depressed, manic, confused, anxious, agitated, panic, delirious, apathetic (par. 4). In the case of nonpsychotic reactions, resemblance, if any, to one of the psychoneurotic reactions or character and behavior disorders will be recorded. If there is no resemblance to any of these, the diagnosis will be amplified by a description of manifestations, such as irritability, memory defect, mild confusion, and so forth. Examples of recording such cases:

(*a*) Syphilis, tertiary, meningo-encephalitic type (general paresis) manifested by psychotic reaction, manic type.

(*b*) Intoxication, bromide, chronic, with psychotic reaction, confused type.

(*c*) Neoplasm, cerebral (specify type if known), left frontal region, with nonpsychotic mental reaction, resembling anxiety reaction.

(*d*) Arteriosclerosis, cerebral, manifested by psychotic reaction, paranoid type, chronic severe.

d. Multiple psychiatric diagnoses.—

(1) Whenever two separate psychiatric conditions exist, such as an antisocial personality reaction and a psychosis, both will be recorded. However, if a diagnostic entity (which would be recorded as the only diagnosis, if encountered as an isolated personality disturbance) is a part of a more extensive process or secondary to it, the primary condition will be recorded as the diagnosis, with the less important or secondary condition given as a manifestation. Examples:

(*a*) Anxiety reaction manifested by somnambulism.
(*b*) Passive-aggressive reaction, manifested by enuresis.
(*c*) Asocial reaction type with sexual sadism.

(2) Some psychiatric conditions are incompatible with certain other psychiatric diagnoses and will not be recorded as existing together, as for instance, psychoneurotic and psychotic reactions; acute situational maladjustment with psychoneurotic or psychotic reactions; or combat exhaustion with psychoneurotic or psychotic reactions.

Many of these conditions may progress from one to another, but are not present simultaneously. Similarly, only one type of psychoneurotic reaction will be used as a diagnosis in such cases, even in the presence of symptoms of another type. The diagnosis will be based on the predominant type, followed by a statement of its manifestations, including symptoms of the other types of reaction. Examples:

(*a*) "Anxiety reaction, with minor conversion symptoms."

(*b*) "Phobic reaction, manifested by claustrophobia, with obsessive-compulsive symptoms, counting and recurring thought, and so forth."

Section IV.—Additional Requirements for Recording of Psychiatric Conditions on Clinical Records

12. Recording Requirements

a. General.—The general requirements outlined in section III for the recording of diagnoses on the individual medical records apply to the recording of diagnoses on the clinical records. In view of the fact, however, that the clinical records fulfill a wider function than the individual medical records, the mere stating of the diagnosis (including its qualifying terms) is not sufficient for certain conditions, since it does not furnish enough information to describe their clinical picture. Thus, for example, a diagnosis "anxiety reaction" does not convey whether the illness has occurred in a previously normal or in a previously neurotic personality. Furthermore, it does not indicate the degree and nature of the external stress; nor does it reveal the extremely important information as to the degree to which the patient's functional capacity has been impaired by the psychiatric condition. Therefore, for certain conditions (par. 12*b*), a complementary diagnostic evaluation will be entered in the clinical records. This additional evaluation will consist of the following elements: (1) External precipitating stress (par. 13); (2) premorbid personality and predisposition (par. 14); and (3) degree of resultant psychiatric impairment (par. 15).

The complimentary diagnostic evaluation for such cases will be recorded by the medical installation in which the medical officer has sufficient opportunity and information to do so. Whenever the medical officer lacks such opportunity or information, he should so indicate with the term "unknown" or "undetermined." It is extremeley important that the medical officers of the patient's own unit, and others who work with the case in its early stages should indicate the external stress, even though they may lack opportunity to determine predisposition.

It is essential to recognize that the time element is all important in this evaluation: the diagnostic formulation on any particular date may (and in many cases should) be changed on a subsequent date. A patient may show marked impairment upon admission to a hospital, but a few days later may be able to return to duty with minor or no impairment. The diagnosis alone will not determine the disposition of the case without consideration of the stress, predisposition, and functional incapacity, whenever these elements are reported. Under the present system the diagnosis becomes only one of the four factors to be considered in determining disposition.

b. Conditions requiring complementary diagnostic evaluation.

(1) Transient personality disorders due to acute or special stress.
(2) All types of psychoneurotic disorders.
(3) Immaturity reactions.
(4) Psychoses.

No complementary evaluation will be made for character and behavior disorders (except for immaturity reactions); mental deficiency; and psychiatric disorders with demonstrable etiology or associated structural changes in the brain.

13. External Precipitating Stress

Under this heading, the external stress precipitating the condition is to be evaluated as to type, degree, and duration. The stress will generally refer to the environmental situation, military or otherwise, which is the direct cause of the reaction manifest in the patient. Unconscious internal conflicts will not be considered external stresses.

A judgment of military stress can be made most accurately by the medical officer of the patient's own unit, since living in the same environment qualifies him to do so. The opinion of the individual's commanding officer should likewise be of value. It may be more difficult for the hospital psychiatrist to evaluate the stress to which the patient has been subjected. Whenever the stress cannot be determined, it should be recorded as either "unknown," or "undetermined."

The degree of stress, whether that of combat, regimentation, training, isolation, or other type, must be evaluated in terms of its effect on the "average man" of the group. It should not be presumed that a particular environmental stress is severe because one or even several individuals react poorly to it, since these individuals may have had poor resistance to stress. Stress will be classified as "severe," "moderate," or "minimal." "Severe stress" is such that the average man, when exposed to it, could be expected to develop disabling psychiatric symptoms. "Moderate stress" is such that a measurable causal relationship can be established between the symptoms and the precipitating factors. "Minimal stress" is such that the average man could be exposed to it without developing psychiatric symptoms. Examples or recording stress: "Severe stress of 60 days continuous combat as a rifleman;" (or "of 60 days under continuous general quarters," or "of 30 hazardous aerial combat missions" or "of 4 hazardous amphibious operations"; "Moderate stress of serious chronic domestic problems;" "stress unknown."

14. Premorbid Personality and Predisposition

The description of the predisposition will consist of a brief statement of the patient's outstanding personality traits or weaknesses which have resulted from inheritance and development, and an evaluation of the degree of predisposition based on past history and personality traits. The degree of predisposition will be recorded as "No predisposition evident;" "Mild predisposition;" "Moderate predisposition;" or "Severe predisposition."

a. No predisposition evident.—This description will be used when the patient shows no evidence of previous personality traits or makeup appearing to be related to his present illness, and when there has been no positive history of a psychoneurotic or other mental illness in his immediate family.

b. Mild predisposition.—This description will be used when the patient's history reveals mild transient psychological (emotional)

upsets and abnormal personality traits, or defect of intelligence which, however, did not significantly incapacitate the patient, or did not require medical care. It will also be used when there is a past history of mental illness in the patient's family.

c. Moderate predisposition.—This description will be used when the patient has a personal history of partially incapacitated psychological (emotional) upsets or abnormal personality traits or defects in intelligence which resulted in his social maladjustment.

d. Severe predisposition.—This description will be used in the presence of the patient's definite history of previous overt emotional or mental illness or disorder.

15. Degree of Psychiatric Impairment

The psychiatric disability represents the degree to which the individual's total functional capacity has been impaired by the psychiatric condition. This is not necessarily the same as general ineffectiveness. (Effectiveness in any particular job is a resultant of the individual's emotional stability, intellect, physical condition, attitude, training, and so forth, as well as of the degree and type of his psychiatric impairment. Depending upon other circumstances a man with a moderate phychiatric impairment may be more effective than another man with a minimal impairment). Degree of impairment as used here refers only to ineffectiveness resulting from the current psychiatric impairment.

The degree of impairment at the time of original consultation or admission to the hospital will often vary from the degree of impairment after treatment. Impairment at the termination of treatment represents the residual or persistent impairment. Depending on the degree of the impairment, it will be recorded as "No impairment," "Minimal impairment," "Moderate impairment," or "Marked impairment." The individual's capacity to perform military service will be used as the base-line for estimating the degree of impairment.

a. No impairment.—This term will be used, whenever in the opinion of the medical officer, there are no medical reasons for changing the patient's current assignment or duty. An individual may have certain symptoms and yet have no medical reason for not performing full duty. For instance, symptoms of an anxiety state are present in the majority of military personnel engaged in combat; individuals returned to duty with mild symptoms may fail to function because of their attitude and not because of the severity of their illness.

b. Minimal impairment.—This term will be used to indicate a slight residual degree of impairment in the patient's ability to carry on in his current assignment or duty.

c. Moderate impairment.—This term will be used to indicate a residual degree of impairment which seriously, but not totally, interferes with the patient's ability to carry on in his current assignment or duty.

d. Marked impairment.—This term will be used to indicate a residual degree of impairment which totally prevents the patient from satisfactorily functioning in his current assignment. It may be temporary or permanent.

16. Manner of recording

The manner of recording of diagnoses on clinical records is illustrated by the following examples:

a. Acute situational maladjustment, manifested by anxiety, asthenia, and poor efficiency, severe; severe stress, due to loss of business property without insurance coverage; no predisposition evident; recovered under psychotherapy; no impairment.

b. Obsessive-compulsive reaction, chronic, moderate, manifested by counting, recurring thoughts, and ceremonials; minimal stress; moderate predisposition, with history of emotional upsets since childhood; moderate impairment.

c. Phychogenic gastrointestinal reaction, manifested by nausea, vomiting, loss of appetite, and epigastric pain, moderate, chronic; moderate stress of 200 combat days as rifleman (or "10 aerial combat missions," or "20 days constant general quarters condition aboard destroyer"), moderate predisposition, with neurotic personality since childhood; minimal impairment.

d. Schizophrenic reaction, hebephrenic type, severe, chronic; minimal stress (unit alerted for overseas); severe predisposition, with marked schizoid features since childhood; marked impairment (requires hospitalization).

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